2007 Employee	**UnitedHealthcare Premier PPO**		**CIGNA Premier PPO**		**UnitedHealthcare Standard PPO**		**CIGNA In-Network Plan**	**Kaiser (CA) HMO**
Type of Plan	**Preferred Provider Organization – PPO**		**Preferred Provider Organization – PPO**		**Preferred Provider Organization – PPO**		**Exclusive Provider Organization (EPO) (An HMO "Look - Alike")**	**Health Maintenance Organization – HMO**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network Only**
Annual Calendar Year Deductible	Individual: N/A Family: N/A	Individual: $500 Family: $1,500	Individual: N/A Family: N/A	Individual: $500 Family: $1,500	Individual: $1,000 Family: $3,000	Individual: $2,000 Family: $6,000	Individual: None Family: None	Individual: None Family: None
Annual Calendar Year Out-of-Pocket Maximum	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000	Individual: $2,500 Family: $5,000	Individual: $5,000 Family: $10,000	Individual: $1,500 Family: $3,000	Individual: $1,500† Family: $3,000 (two or more)
Preventive Care								
Annual Routine Physical (age 11 & over)	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	$15 copay
Well Baby/Child Exam (0 to 10 yrs.)	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	No Copay 0-23 months ($15 Copay 2 to 10 years)
Immunizations/Flu Shots**	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	No Copay
Certain Cancer Screenings	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	No Copay
Outpatient Services								
Office Visit – PCP	$15 copay•	30%* of U&C	$15 copay•	30%* of U&C	$15 copay•	30%* of U&C	$15 copay	$15 copay
Office Visit – Specialist	$25 copay•	30%* of U&C	$25 copay•	30%* of U&C	$25 copay•	30%* of U&C	$25 copay	$15 copay
Urgent Care	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$40 copay per visit	$15 copay per visit
Emergency Room	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$100 per visit	$100 per visit (waived if admitted)
Outpatient Surgery	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$100 copay	$50 copay per procedure
Allergy Treatment								
• Testing	$25 copay	30%* of U&C	$25 copay	30%* of U&C	$25 copay•	30%* of U&C	$25 copay	$15 copay
• Serum	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
• Shot Only	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$10 copay	$5 copay
Chiropractic/Acupuncture	15% of negotiated fees[1]	30%* of U&C [1]	15% of negotiated fees[1]	30%* of U&C [1]	20%* of negotiated fees [2]	30%* of U&C [2]	$15 copay per visit [3]	$15 copay per visit [7]
Speech, Physical/ Occupational Therapy	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$15 copay per visit [3]	$15 copay per visit (max. of 60 consecutive days/condition/lifetime)
Lab/Radiology (Outpatient)	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
Maternity Care								
Pre/Postnatal Visits	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
Delivery Charge	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	See Inpatient Admit	See Inpatient Admit
Hospital Services								
Inpatient Admit	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$200 per day up to $500	$250 per admission
Ambulance	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	$50 copay	$75 copay
Hospice (Inpatient)	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
Skilled Nursing Facility	15% of negotiated fees	30%* of U&C	15% of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay Limit of 60 days/CY	No copay••
Other Benefits								
Durable Medical Equipment/ External Prosthetic Appliances	15% of negotiated fees Pre-authorization required for over $1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over $1000 purchased or cumulative rental value	15% of negotiated fees Pre-authorization required for over $1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over $1000 purchased or cumulative rental value	20%* of negotiated fees Pre-authorization required for over $1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over $1000 purchased or cumulative rental value	No copay [8] EPA - $200 deductible, then no charge	No copay
Prescription Drugs								
Retail								
• Generic	20% of retail network price with a $6 minimum and $12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20% of retail network price with a $6 minimum and $12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20% of retail network price with a $6 minimum and $12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	$10 copay (up to 30-day supply)	$10 copay (up to 30-day supply)
• Brand-Name	Preferred—30% of retail network price with a $25 minimum and $40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Preferred—30% of retail network price with a $25 minimum and $40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Preferred—30% of retail network price with a $25 minimum and $40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	$30 copay (up to 30-day supply)	$25 copay (up to 30-day supply)
	Non Preferred—40% of retail network price with a $40 minimum and $60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Non Preferred—40% of retail network price with a $40 minimum and $60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Non Preferred—40% of retail network price with a $40 minimum and $60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	N/A	N/A
Mail Order								
• Generic	$18 copay (up to 90-day supply)	N/A	$18 copay (up to 90-day supply)	N/A	$18 copay (up to 90-day supply)	N/A	$20 copay (up to 90-day supply)	$20 copay (up to 100-day supply)
• Brand-Name	Preferred—$65 copay (up to 90-day supply)	N/A	Preferred—$65 copay (up to 90-day supply)	N/A	Preferred—$65 copay (up to 90-day supply)	N/A	$60 copay (up to 90-day supply)	$50 copay (up to 100-day supply)
	Non Preferred—$100 copay (up to 90-day supply)	N/A	Non Preferred—$100 copay (up to 90-day supply)	N/A	Non Preferred—$100 copay (up to 90-day supply)	N/A	N/A	N/A
Behavioral Health								
Mental Health								
• Inpatient	15% of negotiated fees[4] (max. of 90 days/CY)	50%* of U&C[4] (max. of 90 days/CY)	15% of negotiated fees[4] (max. of 90 days/CY)	50%* of U&C [4] (max. of 90 days/CY)	20%* of negotiated fees [5] (max. of 60 days/CY)	50%* of U&C [5] (max. of 60 days/CY)	$200 per day up to $500 (max. of 45 days/CY)	$250 copay (max. of 45 days/CY)
• Outpatient	15% of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	15% of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	20%* of negotiated fees [6] (max. of 20 visits/CY)	50%* of U&C [6] (max. of 20 visits/CY)	$25 copay (max. of 30 visits/CY)	$15 copay (20 ind./group therapy visits/CY with 20 additional group therapy visits if criteria met)
Substance Abuse								
• Inpatient	15% of negotiated fees[4] (max. of 90 days/CY)	50%* of U&C[4] (max. of 90 days/CY)	15% of negotiated fees[4] (max. of 90 days/CY)	50%* of U&C[4] (max. of 90 days/CY)	20%* of negotiated fees [5] (max. of 60 days/CY)	50%* of U&C [5] (max. of 60 days/CY)	$200 per day up to $500 (max. of 15 days/CY)	$250 copay Transitional Residential Recovery Services $100 copay/stay
• Outpatient	15% of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	15% of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	20%* of negotiated fees [6] (max. of 20 visits/CY)	50%* of U&C [6] (max. of 20 visits/CY)	$25 copay (max. of 30 visits/CY)	$15 copay (unlimited visits)
Employee Assistance Program	Pre-certification required up to eight visits/yr with no copay	N/A	Pre-certification required up to eight visits/yr with no copay	N/A	Pre-certification required up to eight visits/yr with no copay	N/A	Up to eight visits/yr with no copay; pre-certification required	Sandia on-site EAP at no charge up to eight visits/CY (non-Kaiser benefit)

NOTES

The following services (to be provided as determined by consultation between the attending physician and the patient) are covered for members who receive benefits in connection with a mastectomy and who elect breast reconstruction:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prosthesis and physical complications in all stages of mastectomy, including lymphedema.

This coverage is subject to the same deductible, copay, and coinsurance provisions that apply to other benefits under the applicable Plan. There are no limitations on the number of prostheses and no time limitations from the date of the mastectomy.

* Subject to deductible.

**Does not apply to out-patient drugs

†Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts (excludes prescription copays).

• Lab, radiology, chemotherapy and radiation therapy, supplies and diagnostic tests performed in the office will result in a 15% or 20% coinsurance.

•• Benefit period begins 1st day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60-day lapse between confinements.

1 Combined maximum of $1500/ calendar year for In-network and Out-of-network charges for Chiropractic and Acupuncture care.

2 Combined maximum of 10 visits/ calendar year for In-network and Out-of-network charges for Chiropractic and Acupuncture care.

3 Combined maximum of 60 visits/ calendar year for In-network and Out-of-network charges for Chiropractic, Acupuncture, Speech Therapy, Physical Therapy, and Occupational Therapy.

4 Combined maximum of 90 days/ calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse.

5 Combined maximum of 60 days/ calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse.

6 Combined maximum of 20 visits/ calendar year for In-network and Out-of-network charges for Outpatient Mental Health and Outpatient Substance Abuse.

7 Chiropractic care with a maximum of 30 visits/calendar year. Acupuncture allowed with referral for Medical Management of Chronic Pain only.

8 $200 annual deductibles for external prosthetic appliances. Benefit is unlimited.

This information is a condensed summary and does not replace or modify the Summary Plan Description (SPD) for the plans. If there is any discrepancy in the information on this grid and in the SPD, the SPD supercedes.